BOARD OF REGISTRATION OF MASSAGE THERAPY
Instructions for Single Therapist Establishment Application

1. If your establishment will have **one and only one massage therapist**, then this form, the single therapist establishment application, is the correct application form. If your establishment will have more than one therapist, then the Multiple Therapist Establishment Application form is required instead.

2. An application must be submitted for each physical location. Additionally, should you move your establishment after licensure by the Board of Registration of Massage Therapy ("Board"), a new application must be submitted because licenses are not transferable.

3. You must read the regulations: 269 CMR 6.00 et. seq. Go to: www.mass.gov/dpl/mt and select "statutes and regulations." On the next page select "Rules and regulations governing massage therapists." On the next page select "269 CMR 6.00: Facility Licensure."

4. If you answered Question #15(a) in the affirmative, a certificate of standing is required from every **out-of-state** licensure jurisdiction. Certificates are required for all licensure statuses including lapsed, expired, etc. Contact that jurisdiction and have the document mailed to you for inclusion with your application. Please maintain the official **statement(s) in the unopened, jurisdiction-sealed envelope(s) to accompany your application.** The document may also be mailed directly to the Board; however, this may cause a delay in processing your application.

5. Regarding **Question #16**, you must list all offenses including OUI, DUI, and Operating after/with suspended license or registration. Dispositions of "continued without finding" ("CWOF") or "admission to sufficiency of facts" must be reported. Do not include minor traffic offense(s).

6. Both your application and your application checklist must be signed and notarized.

7. Your application must include a floor plan.

8. Your application must include copies of all applicable **local permits**.

9. **If your establishment is required to carry worker's comp insurance, you must provide a copy of the worker's comp insurance policy declarations page that indicates the amount and effective date of coverage.** The policy must reference the establishment. The Board cannot make recommendations about insurers nor can the board provide advice on whether your establishment is required to carry worker's comp insurance.

10. Include a check or money order for **$50.** in U.S. funds made payable to the **Commonwealth of Massachusetts.** The fee is **not** refundable. Please note that your application will not be processed without the correct fee. The initial fee includes both application processing and your first license.

11. **Mail the complete application package to: Board of Massage Therapy, 1000 Washington Street, Suite 710: *Establishment Licensure*, Boston, MA, 02118-6100.**

12. **Please allow 4 – 6 weeks for processing**. If you have any additional questions, please contact the Board via email: feiyan.h.chen@state.ma.us or ana.garcia@state.ma.us or by phone, (617) 727-1747.

The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Registration of Massage Therapy
1000 Washington Street, Suite 710
Boston MA 02118-6100

SINGLE THERAPIST ESTABLISHMENT APPLICATION

BOARD USE ONLY

Fee ($50): ❑ Check/MO #_____

Investigator's Name: _____ Date of Inspection: _____

Received By: _____ ❑CORI sent _____ ❑ CORI rec'd: _____

Application Number_____ License Number: _____

1. Name of Establishment Operator: _____
Last First Middle

2. Massage Therapy License # (if applicable): _____

3. Name/Address of Establishment _____

_____
No. Street P.O. Box

_____
City/Town State Zip Code

4. Contact Information : Day Phone: _____ Evening: _____

E-mail: _____
Please note: EMAIL will be the primary means of contact for routine correspondences during the application process.

5. Name of Massage Therapist: _____
Last First Middle

6. Massage Therapy License #: _____

7. Address of Therapist: _____
No. Street P.O. Box

_____
City/Town State Zip Code

8. Contact Information : Day Phone: _____ Evening: _____

E-mail: _____
Please note: EMAIL will be the primary means of contact for routine correspondences during the application process.

9. Establishment is: ❑ Individually Owned ❑ Partnership ❑ Incorporated or LLC (enclose articles of organization)

If a corporation or LLC, what is the name? _____

If establishment is incorporated, state where: _____

If a corporation or LLC, list names, addresses and phone numbers of the officers:

_____

_____

_____

_____

If a partnership, list names, addresses and phone numbers of the partners. _____

_____

_____

_____

_____

If individually owned, list the name, address and phone numbers of the owner?

_____

_____

_____

10. Location of establishment: ❑ Store ❑ Residence ❑ Office Building ❑ Salon/Spa ❑ Medical Office/Clinic ❑ Physical Therapy Facility ❑ Other _____

11. Has owner obtained all necessary local permits? ❑ Yes (enclose copies) ❑ No

12. Is a floor plan attached (required for all establishments)? ❑ Yes ❑ No

13. Specify how many of each of the items listed below:

Bathrooms _____ Sinks _____ Massage Tables _____ Covered Disposals _____

14. Is this establishment required to carry Worker's Compensation insurance?
Yes: ❑ No: ❑ **If "Yes," provide a copy of the Worker's Comp. insurance policy declarations page.**

15. To be completed for all signatories to this application:

a) List any licenses/certifications any signatory to this application has held in the United States or any country or foreign jurisdiction and the jurisdiction from which the license/certification was originally issued. Please attach a certificate of standing from each jurisdiction outside Massachusetts in which the signatory is licensed/certified, indicating the status of the license and any relevant disciplinary information.

_____
_____
_____
_____

b) Has any disciplinary action been taken against any signatory to this application by a licensing/certification authority located in the United States or any country or foreign jurisdiction? Yes: ❑ No: ❑
If yes, please state the details, including the name of the individual, the type of license, the jurisdiction taking the disciplinary action, the reason for the discipline, and the type of discipline (use a separate sheet if necessary): _____
_____
_____
_____
_____

c) Is any signatory to this application the subject of pending disciplinary actions by a licensing/certification authority located in the United States or any country or foreign jurisdiction? Yes: ❑ No: ❑
If yes, please state the details, including the name of the individual, the type of license, the jurisdiction pursuing the disciplinary action, and the reason for the discipline (use a separate sheet if necessary):
_____
_____
_____
_____
_____

d) Has any signatory to this application ever voluntarily surrendered or resigned a professional license to a licensing/certification authority in the United States or any foreign jurisdiction?
Yes: ❑ No: ❑ If yes, please state the details, including the name of the individual, the type of license, the jurisdiction for which the license was surrendered, and the reason for the surrender (use a separate sheet if necessary):_____
_____
_____
_____
_____

e) Has any signatory to this application ever applied for and been denied a professional license in the United States or any foreign jurisdiction? Yes: ❑ No: ❑ If yes, please state the details, including the name of the individual, the type of license, the jurisdiction in which the license was denied, and the reason for the denial (use a separate sheet if necessary): _____
_____
_____
_____
_____

Establishment operator or manager must notify the Board of Registration of Massage Therapy, thirty (30) days prior, of any change in ownership or location.

16. Has any signatory to this application ever been convicted of, or admitted to a felony or misdemeanor in the United States or any foreign jurisdiction, other than a traffic violation for which a fine of less than $200.00 was assessed? Yes: ❑ No: ❑ If yes, please state the details, including the name of the individual, the jurisdiction in which the events occurred, the dates of the events and of the court decisions, the charges, the verdict(s), and the sentences (use a separate sheet if necessary):_____

_____

_____

NOTE: The Board has received certification by the Criminal History Systems Board (ID# MAREG G) to access data about convictions and pending criminal cases. Your signature on this application allows the Board to conduct criminal background checks for conviction, non-conviction, and pending criminal case information only, on an ongoing basis, and that it will not necessarily disqualify you from licensure (or later license renewal). Other Federal and professional records may also be checked. The Board will not deny you a license (license renewal) based on criminal information prior to giving you an opportunity for a limited appearance before the Board.

17. I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration of Massage Therapy to deny, suspend or revoke any license issued to me in accordance with Massachusetts Law. I further attest that, pursuant to G.L. c. 62C, s. 49A., to the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law.

_____ _____
Signature of Operator Date

_____ ID THEFT INDEX PIN: _____[1]
Birth Date & Soc. Sec. Number

_____ _____
Signature of Massage Therapist Date

_____ ID THEFT INDEX PIN: _____[1]
Birth Date & Soc. Sec. Number

_____ _____
Signature of Owner Date

_____ ID THEFT INDEX PIN: _____[1]
Birth Date & Soc. Sec. Number

On this ____ day of _____, 20__, before me, the undersigned notary public, personally appeared _____ (name[s] of document signer[s]), proved to me through satisfactory evidence of government issued identification, which was/were _____, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose. SEAL

_____ My commission expires _____
Signature of Notary Public

Investigator Only: Please staple a copy of the ITD printout for the above referenced Establishment.

[1] Only applicable if the individual has been enrolled in the NCIC Identity Theft File by the CHSB.

YOU MUST INCLUDE THIS

APPLICATION CHECKLIST

WITH YOUR APPLICATION

I certify, under the pains and penalties of perjury, the truth of the following statements:

- I have read the instructions and all regulations: 269 CMR 6.00 et. seq.
- I have enclosed a completed (signed & notarized) "License Application" form. Each and every question must be answered with the appropriate information. For "Yes/No" questions please answer "Yes," "No" or "Not Applicable"
- If applicable, I have enclosed a copy of the Articles of Corporation of the owning corporation.
- I have enclosed a floor plan of my establishment which includes **measurement specifications**.
- I have enclosed copies of all applicable **local permits**.
- If applicable, I have enclosed a copy of the **Worker's Comp.** Insurance declarations page.
- I have enclosed a Check/Money Order payable to: **Commonwealth of MA** for $50.

MANDATORY
My Social Security Number or Tax Identification Number is:

☐☐☐-☐☐-☐☐☐☐

Pursuant to G.L. c. 62C, § 47A, the Division of Professional Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

_____ _____
Signature of Operator or Owner Date

_____ ID THEFT INDEX PIN: _____[2]
Birth Date

On this ____ day of _____, 20__, before me, the undersigned notary public, personally appeared_____ (name of document signer), proved to me through satisfactory evidence of government issued identification, which was/were _____, to be the person whose name is signed on the preceding or attached document, and acknowledged to me SEAL that (he) (she) signed it voluntarily for its stated purpose.

_____ My commission expires _____
Signature of Notary Public

Mail your application materials to: Board of Massage Therapy, 1000 Washington Street, Suite 710: Establishment Licensure, Boston, MA, 02118-6100.

[2] Only applicable if the individual has been enrolled in the NCIC Identity Theft File by the CHSB.